# COMMONLY REPORTED HEALTH PROBLEMS
# Recent findings

## OVERVIEW

- There are many symptoms and health problems which are commonly reported in later life
- These are sometimes related to specific diseases or chronic disorders but often they are not
- Regardless of their underlying causes these symptoms can have a major impact on social participation and quality of life
- At age 68 comprehensive assessments of key symptoms including sleep problems, pain, fatigue, falls and incontinence were undertaken

Our overall aims are to use these new data, alongside previous reports of these symptoms, to:

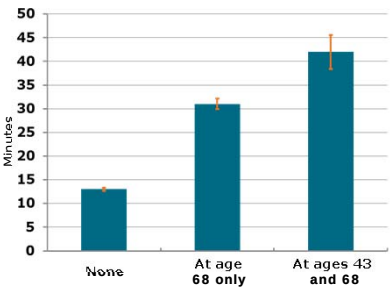
1. Characterise the inter-relationships between these symptoms and chronic conditions
2. Examine factors across life that influence risk of experiencing these symptoms
3. Identify modifiable factors which minimise the impact of these symptoms on quality of life, participation and capability

Here we showcase preliminary findings on some of these measures

## SLEEP
## (S Black and M Stafford)

- Sleep and related problems have been assessed across life in the NSHD
- For example, between ages 48 and 54, it was found that trouble sleeping was a common problem among women and was related to prior health status [Tom et al 2009]
- At age 68, sleep was assessed using the Pittsburgh Sleep Quality Index. An overall score is derived based on 7 components of sleep: **quality, latency, duration, habitual sleep efficiency, sleep disturbance, use of sleep medication, daytime dysfunction**
- Based on this index, 44% of women and 28% of men were classified as having poorer sleep quality
- For many people sleep problems are chronic; 60% of those that reported recurring sleep problems at age 43 were classified as having poorer sleep quality at age 68

**Fig 1: Mean time (mins) to fall asleep by sleep problems at ages 43 & 68**



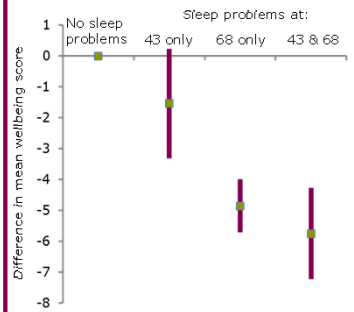




**Fig 2: Mean differences in wellbeing score at age 68 by sleep problems at ages 43 & 68**

- Those reporting sleep problems at ages 43 and 68 had:
  (1) longer mean time to fall asleep (Fig. 1)
  (2) lower mean wellbeing scores (Fig. 2)

## CHRONIC PAIN
## (S Muthuri and R Cooper)

- Chronic pain (i.e. pain which has lasted for 3 months or more) negatively influences physical capability and impacts on quality of life, wellbeing and activity participation
- In NSHD, the overall prevalence of chronic pain at age 68 was 41.2%, with more women (57.5%) than men (42.5%) reporting this (Fig. 1)
- There was also a higher burden of chronic pain among those who reported poor or fair health vs good/excellent health (Fig. 2)

**Fig 1: Prevalence of pain at age 68y**

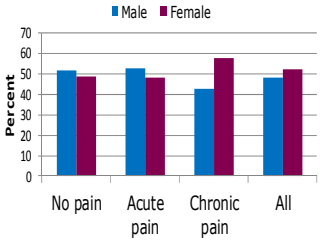
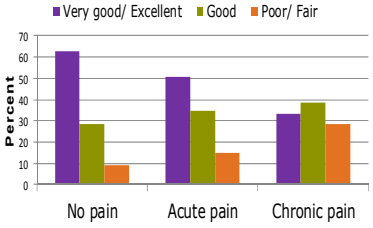



**Fig 2: Prevalence of self-reported health by pain**

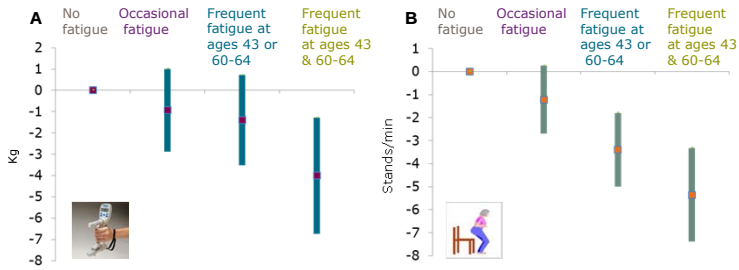



- Preliminary work on early life factors associated with pain suggest that those who experienced chronic physical illness before age 25 years had a higher likelihood of chronic widespread pain at age 68 than those with no history of serious illness (relative risk ratio=1.43 (95%CI 1.05 -1.95))

## FATIGUE
## (M Popham and R Cooper)

- Reductions in energy availability with increasing age may partially explain age-related declines in activity participation and physical capability
- Previous work in the NSHD supports this; study participants who reported fatigue at ages 43 and 60-64 had poorer physical performance and weaker strength at age 60-64 than those who reported no fatigue (Fig.1) [Manty et al, 2015]

**Fig 1: Mean differences (95% confidence intervals) in [A] grip strength (kg) and [B] chair rise speed (stands/min) by fatigue at ages 43 and 60-64**




- At age 68 the Pittsburgh Fatigability Scale was used to assess 'fatigability' i.e. perceived exertion when performing a list of specific tasks
- Those with higher levels of physical fatigability (i.e. score ≥15) at age 68 were more likely to be inactive than those with lower levels (Fig. 2)

**Fig 2: Prevalence (%) of leisure time physical activity by physical fatigability at age 68**